CITY OF TEMPE
BENEFITS ENROLLMENT/CHANGE FORM (July 1 – June 30)

☐ New Enrollment ☐ Plan Change	❑ Dependent Change ❑ **Beneficiary Change**	**Qualifying Event** **Date**_____ ☐ Marriage/Divorce ☐ Newborn ☐ Loss/Commencement of Coverage	(Office use only) Effective Date: _____

PERSONAL INFORMATION

Employee Last Name	First Name MI	SSN	Employee ID Number

Address Apartment #	City State Zip	Date of Birth

Home Phone	Work Phone	Marital Status	Sex	Spouse employed with City of Tempe: Yes ☐ No ☐	☐ Part-time ☐ Full-time

COVERAGE

MEDICAL
- ❑ High Option PPO
- ❑ Low Option PPO
- ❑ Catastrophic PPO
- ❑ CIGNA HMO
- ❑ Opt-Out Medical (Full-time employees: Complete a Waiver Certificate)

LEVEL OF COVERAGE
- ❑ Employee Only
- ❑ Employee/Spouse
- ❑ Employee/Child(ren)
- ❑ Employee/Family
- ❑ Emp/Domestic Partner
- ❑ Emp/Dom Partner/Child(ren)

DENTAL
- ☐ Metlife High Option
- ☐ Metlife Low Option
- ☐ Cigna Dental
- ☐ No Dental

LEVEL OF COVERAGE
- ☐ Employee only
- ☐ Emp + 1 dependent (i.e. spouse/child)
- ☐ Emp + 2 or more dependents
- ☐ Emp + Domestic Partner
- ☐ Emp + 2 or more (incl Dom Partner)

VISION
- ☐ Vision Services Plan
- ☐ No Vision

LEVEL OF COVERAGE
- ☐ Employee only
- ☐ Emp + 1 dependent (i.e. spouse/child)
- ☐ Emp + 2 or more dependents
- ☐ Emp + Domestic Partner
- ☐ Emp + 2 or more (incl Dom Partner)

Dependent Care Spending Account (Thru Dec 31 of current year)
- ❑ No
- ❑ Yes Deduction per paycheck: $_____ Annual Amount $_____
  (Maximum $5000 per year, $2500 if married filing separately)

Health Care Reimbursement Account
- ❑ No
- ❑ Yes Deduction per paycheck: $_____ Annual Amount $_____
  (Maximum $4000 per year)

VOLUNTARY LIFE
- ❑ Enroll in Voluntary Life. **Complete Voluntary Life Form in packet.**
- ❑ Cancel or decrease Employee Voluntary Life to $ _____
- ❑ Cancel or decrease Spouse Voluntary Life to $_____
- ❑ Cancel Child Voluntary Life

VOLUNTARY AD&D
- ❑ Employee Only Amount $_____
- ❑ Employee/Family ($25k-$500k in $25k increments)
- ❑ Employee/Children
- ❑ None

LIST ALL DEPENDENTS TO BE ENROLLED

Last/First/MI	SSN	Date of Birth	Sex	Add/ Drop	Coverage
Employee					❑ Medical ❑ Dental ❑ Vision
Spouse					❑ Medical ❑ Dental ❑ Vision
Domestic Partner (**Affidavit required)**					❑ Medical ❑ Dental ❑ Vision
Dependent 1					❑ Medical ❑ Dental ❑ Vision
Dependent 2					❑ Medical ❑ Dental ❑ Vision
Dependent 3					❑ Medical ❑ Dental ❑ Vision
Dependent 4					❑ Medical ❑ Dental ❑ Vision

Please turn this form over, complete information on back, and sign and date the form before returning to Human Resources.

For Office Use Only:

Effective Date:	Deduction Date	Initial

QUESTIONS??? CALL 350-8279 OR 350-8080

BENEFICIARY INFORMATION (Basic Life, Basic AD&D, Voluntary Life, Voluntary AD&D, Commuter AD&D)	
Primary _____ % _____ _____ %_____	Relationship _____ Relationship _____
Contingent _____ % _____ _____ % _____	Relationship _____ Relationship _____
Signature _____	Date _____

AUTHORIZATION

I hereby apply for group benefits provided under the City of Tempe's group plan(s) and authorize payroll deductions, if required, for the cost of coverage. I understand that deductions for medical, dental and vision are on a pre-tax basis unless I specify otherwise in writing to the Human Resources Department. These elections will remain effective until revoked by a subsequent election in writing. Participation in the HealthCare Reimbursement Account and Dependent Care Flexible Spending Account requires annual re-enrollment. Under penalty of perjury, by my signature below, I swear and affirm that all representation as to dependents, spouse, and me are true and correct.

Signature _____ Date_____

WAIVER OF COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Signature _____ Date_____

NOTES:

- All benefits (except Dependent Care Spending Account) are on a July 1 – June 30. Your next opportunity to change medical, dental and vision elections will be in the spring for a July 1 effective date.
- All employees complete Type of Change section.
- If you are electing benefits for the first time, complete all sections.
- If you are changing your benefit elections, complete the Personal Information section and any other sections where a change is being made. (IMPORTANT: Include appropriate documentation of why change is being requested: birth certificate, marriage certificate, divorce decree, proof of loss of coverage, etc.). **Form must be received in Employee Benefits within 30 days following the qualifying event.**
- Your election for the Dependent Care Spending Account is for a **CALENDAR YEAR (January 1 – December 31)**. Please estimate your child care expenses through December 31 of the current year only. You will be given the opportunity to re-enroll in the fall for the upcoming year.
- If you are changing your beneficiary only, complete the Personal Information section and the Beneficiary Information section.
- If you are enrolling a dependent child age 19 or over, include documentation of full-time student status or proof of mental/physical handicap.
- If enrolling Domestic Partner completion of Domestic Partner Affidavit is required, along with supporting documentation.
- Sign and date the form. Return to Human Resources/Employee Benefits.

INFORMATION REGARDING DOMESTIC PARTNERSHIP COVERAGE

In addition to all other rules and conditions of City insurance coverage, the following apply to domestic partners coverage: In order for an employee to enroll a domestic partner for insurance coverage, both the employee and the domestic partner must complete the Domestic Partnership Affidavit. The portion of the insurance premium paid by the employee for domestic partner and children of the domestic partner is paid on an after-tax basis. The portion of the premium paid by the City for domestic partner and children of the domestic partner is reported to the Internal Revenue Service as taxable income to the employee. City employees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. **Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage.**

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, **you must request enrollment within 30 days** after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or to obtain more information, contact HR Benefits at 480-350-8278.

General Notice of the Plan's Pre-existing Condition Exclusion (not applicable to CIGNA HMO Plan)

This Plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a three-month period. Generally, this three-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the three-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. **However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage."**

- Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days.
- To reduce the 12-month (or 18- month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have.
- If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to HR Benefits at 480-350-8278.